KING AIRWAY DEVICE (PERILARYNGEAL) – PEDIATRIC (Less than 15 years of age)

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Use of the King Airway adjunct may be performed only on those patients who meet **ALL** of the following criteria:

    a. Unresponsive, agonal respirations (less than 6 per minute) or apneic.

    b. No gag reflex.

    c. Pediatric patients meeting the following criteria:

        i. 35-45 inches or 12-25 kg: Size 2 (connector color: green)

        ii. 41-51 inches or 25-35 kg: Size 2.5 (connector color: orange).

ADDITIONAL CONSIDERATIONS

1. BVM management not adequate or effective.
2. A King Airway adjunct should not be removed unless it becomes ineffective.
3. Medications may **NOT** be given via the King Airway.

CONTRAINDICATIONS

1. Conscious patients with an intact gag reflex.
2. Known ingestion of caustic substances.
3. Suspected foreign body airway obstruction (FBAO).
4. Facial and/or esophageal trauma.
5. Patients with known esophageal disease (cancer, varices, surgery, etc.).
6. Epiglottitis
7. Airway burns

PROCEDURE

1. Using the information provided, choose the correct KING LT size based on patient height.

2. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 2: 25–35 ml; size 2.5: 30-40 ml). Prior to insertion, disconnect Valve Actuator from Inflation Valve and remove all air from both cuffs.

3. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube taking care to avoid introduction of lubricant in or near the ventilatory openings.

4. Have a spare KING LT ready and prepared for immediate use.

5. Pre-oxygenate.

6. Position the head. (The ideal head position for insertion of the KING LT is the "sniffing position.")

7. Hold the KING LT at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.

8. With the KING LT rotated laterally 45-90°, introduce tip into mouth and advance behind base of tongue.

9. Rotate the tube back to the midline as the tip reaches the posterior wall of the pharynx.

10. Without exerting excessive force, advance KING LT until base of connector is aligned with teeth or gums.

11. Holding the KLT 900 Cuff Pressure Gauge in non-dominant hand, inflate cuffs of the KING LT to 60 cm H20. If a cuff pressure gauge is not available and a syringe is being used to inflate the KING LT, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (just seal volume).

12. Attach the breathing circuit to the 15 mm connector of the KING LT. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

13. Reference marks are provided at the proximal end of the KING LT which when aligned with the upper teeth give an indication of the depth of insertion.

14. Confirm proper position by auscultation, chest movement and/or verification of CO2 by capnography.

15. Re-adjust cuff inflation to 60 cm H2O (or to just seal volume).

16. Secure KING LT to patient.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, attached is an Incident Report that must be filled out and forwarded to ICEMA within one (1) week by the receiving hospital.